



Tennessee Board Of Podiatric Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
(615) 741-5735 or (800) 778-4123, ext. 741-5735
<http://www.tn.gov/health/>

INSTRUCTIONS FOR LICENSURE AS AN ORTHOTIST, PROSTHETIST OR PEDORTHIST

The enclosed application and instructions are pertinent for those Orthotists, Prosthetists, and Pedorthists who are applying for licensure.

The requirements for application are supported by T.C.A. Sections 63-3-201 through 63-3-213 and Rules and Regulations Chapter 1155-04, which can be found at: <http://tn.gov/health/article/Podiatric-statutes>.

It is suggested all documents listed in the instructions be requested from the appropriate institutions or individuals upon receipt of this package. All supporting documents must be received in the Board's administrative office by the time frames indicated in the instructions. Please allow ten (10) working days for the information submitted to be received and placed in your file. Mail delivered by Federal Express and other special courier services will be handled as routine mail.

METHODS OF LICENSURE

The licensure method for individuals who have completed a orthotist education program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization, and obtained a baccalaureate degree (or completed the number of semester hours equivalent to four (4) years of study at a four-year college or university) and who have successfully completed a clinical residency in orthotics and successfully completed all required examinations.

The licensure method for individuals who have completed a prosthetic education program accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization, and obtained a baccalaureate degree (or completed the number of semester hours equivalent to four (4) years of study at a four-year college or university) and who have successfully completed a clinical residency in prosthetics and successfully completed all required examinations.

The licensure method for individuals who possess a high school diploma or comparable credential approved by the Board and successfully completed a pedorthics education program accredited by the Board for Certification in Pedorthics, or a pedorthics education program approved by the board and who have successfully completed a qualified work experience program or internship in pedorthics in accordance with standards and procedures established by the Board, and successfully completed all required examinations.

Instructions for Licensure

The following items must be submitted to the Board Office no later than thirty (30) days prior to the next scheduled board meeting.

Procedures for Licensure as an Orthotist, Prosthetist, or Pedorthist

1. Completed application indicating type of requested licensure.
2. The application fee of three hundred and ten dollars \$310 non refundable (\$300 application fee and \$10 state regulatory fee).
3. One (1) passport style photograph taken within the last twelve (12) months.
4. All applicants must complete the Declaration of Citizenship form and have it notarized. The declaration can be found at: <http://tn.gov/assets/entities/health/attachments/PH-4183.pdf>
5. Criminal background check. For information click <http://www.tn.gov/health/topic/CBC-check> for instructions.

SECTION I - Instructions for Licensure as an Orthotist and/or Prosthetist

6. Verification of successful completion of the following:

Use Attachment 1

Certificate of completion of approved educational program in Orthotists/Prosthetists which is accredited by the Commission on Accreditation of Allied Health Education Programs or its successor organization; and

7. Request that an official transcript be mailed from the educational institution at which you completed your baccalaureate degree directly to the Board of Podiatric Medical Examiners. The transcript must indicate date graduated and degree awarded. If you do not have a baccalaureate degree, you must have completed the number of semester hours which is equivalent to 4 years of study at a four-year college or university). The curriculum of the program of study completed must include mathematics, physics, biology, chemistry, anatomy, biomechanics, pathology, and psychology.
8. Verification of successful completion of one of the following:

Use Attachment 2

Orthotist

A clinical residency in orthotics. The majority of training must be devoted to services performed under the supervision of an orthotist licensed in Tennessee or a person in another state who has obtained certification from the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification.

Prosthetist

A clinical residency in prosthetics. The majority of training must be devoted to services performed under the supervision of a prosthetist licensed in Tennessee or a person in another state who has obtained certification from the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification.

9. Verification of Licensure in any other state:

If you are or have ever been licensed, certified, registered, or permitted by any state to practice as an orthotist, prosthetist, or pedorthist (or any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's office from the other state(s).

10. Exam request - An applicant for licensure as an orthotist, prosthetist, or pedorthist must successfully complete and make a passing score on the examination(s) approved and offered by the American Board for Certifications in Orthotics and Prosthetics, Inc., the Board for Certification in Pedorthics, or other examination(s) approved by the board. Please request that your exam scores be sent directly to the Board.

11. Complete jurisprudence examination.

SECTION II - Instructions for Licensure as a Pedorthist

1. Possess a high school diploma or comparable credential approved by the Board; and

2. Verification of successful completion of the following:

Use Attachment 1

Successfully complete a pedorthics education program accredited by the Board of Certification in Pedorthics, or a pedorthics education program approved by the Board

3. Verification of completing the following:

Use Attachment 3

Successfully complete a qualified work experience program or internship in pedorthics:

4. Verification of Licensure in any other state:

If you are or have ever been licensed, certified, registered, or permitted by any state to practice as an orthotist, prosthetist, or pedorthist (or any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's office from the other state(s).

5. Exam request - An applicant for licensure as an orthotist, prosthetist, or pedorthist must successfully complete and make a passing score on the examination(s) approved and offered by the American Board for Certifications in Orthotics and Prosthetics, Inc., the Board for Certification in Pedorthics, or other examination(s) approved by the board.

**American Board for Certification in Orthotics,
and Prosthetics**
330 John Carlyle Street
Suite 210
Alexandria, VA 22314

Board for Certification in Pedorthics
10451 Mill Run Circle
Suite 200
Owings Mills, MD 21117
info@abcop.org

6. Complete jurisprudence examination.

A completed file is one which contains ALL of the required documentation.

ATTACH
PHOTO
HERE



2217) 001 \$ 300
2217) 006 \$ 10
2218) 001 \$ 300
2218) 006 \$ 10
2219) 001 \$ 300
2219) 006 \$ 10

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APPLICATION FOR REGISTRATION AS AN ORTHOTIST, PROSTHETIST, PEDORTHIST
(Must Type or Print)

PLEASE CHECK ONE: _____ Orthotist _____ Prosthetist _____ Pedorthist

(You may only apply for one license per application. If you are credentialed for more than one of the three licenses listed above, you must submit a separate application and accompanying fee for each.)

Name: _____
Last First Middle Maiden

Current Home Mailing Address: _____ Current Practice Name and Address: *

*If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.

Phone (Home): _____ (Work): _____

U. S. CITIZEN: Yes _____ No _____ Entitled to Live and Work in the U.S.: Yes ___ No ___
All applicants must complete the Declaration of Citizenship form and have it notarized.

Social Security Number: _____ - _____ - _____ Date of Birth: _____

E-Mail: _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. Yes _____ No _____

Gender: Female _____ Male _____ Race: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes _____ No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)
Yes ___ No ___

Have you ever been known by any other names besides what is listed above? Yes _____ No _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

EDUCATIONAL INFORMATION:

NAME OF SCHOOL

DATES ATTENDED

DEGREE

A. _____
B. _____
C. _____

CLINICAL RESIDENCY IN ORTHOTICS OR PROSTHETICS

Are you currently enrolled in a Clinical Residency? Yes _____ No _____

If yes, Name of Residency: _____

Address: _____

Name of Supervisor: _____

License/Certificate No: _____ State where Licensed/Certified: _____

If seeking licensure by reciprocity are you currently certified in orthotics by either the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification?

Yes* _____ No _____

Are you currently certified in prosthetics by either the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification?

Yes* _____ No _____

Are you currently certified in pedorthics by the Board of Certification in Pedorthics, Inc., the American Board for Certification in Orthotics and Prosthetics, Inc. or Board for Orthotist/Prosthetist Certification?

Yes* _____ No _____

*** If yes, please attach a copy of the current certificate(s).**

LICENSURE INFORMATION

List below states in which you have ever been or are currently licensed as a podiatrist.

STATE LICENSED	LICENSE NUMBER	DATE ISSUED
_____	_____	_____
_____	_____	_____
_____	_____	_____

List below states in which you hold a license as a health professional other than a Podiatrist

STATE LICENSED	LICENSE NUMBER	DATE ISSUED
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Request Verification of Licensure" be sent directly to this board from each state in which you now hold or have ever held licensure.)

EMPLOYMENT INFORMATION

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

<u>Company/ Employer:</u>	<u>Address:</u> (City, and State)	<u>Position:</u>	<u>Duties:</u>	<u>Dates</u>	
				<u>From:</u> Mo./Yr.	<u>To:</u> Mo./Yr.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

(This space intentionally left blank)

COMPETENCY QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.

YES NO

- | | | | |
|----|---|-----|-----|
| 1. | Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? | ___ | ___ |
| 2. | Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? | ___ | ___ |

If so, please list: _____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]

		YES	NO
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of illicit or controlled substances?	___	___
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice dentistry in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10.	Have you ever been rejected or censured by a professional association or society?	___	___
11.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	___	___
	b. Have you ever entered into any settlement of any legal action; or	___	___
	c. Are there any legal actions pending against you or to which you are a party?	___	___
12.	Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___



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**CERTIFICATE OF COMPLETION OF APPROVED EDUCATIONAL
PROGRAM IN ORTHOTICS / PROSTETICS / PEDORTHICS**

This is to certify that _____, a participant of
(Applicant's Name)

_____, participated in an approved educational program
(Name of Program)

offered by _____
(Name and Address of Facility)

from _____ thru _____ and that the above named participant successfully completed this program
(Date) (Date)

on _____.
(Date)

_____ was the program director for the participant named above during the program indicated and that he/she has carefully read and completed this form and that the statements made herein are strictly true in every respect. Verification of the program must be submitted on your official letterhead.

(Type or Print Name of Program Director)

(Name of Program)

(Street and Number)

(City) (State) (Zip)

()

(Phone Number)

(Signature of Program Director)

NOTE: Approved educational programs are those programs accredited by the Commission on Accreditation of Allied Health Education Programs or its successor or a baccalaureate degree or number of semester hours equivalent to four (4) years of study at a four-year college or university pursuant to Rule 1155-04-.06(1)(b) and Rule 1155-04-.06(2)(b).



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VERIFICATION OF COMPLETION OF CLINICAL RESIDENCY
IN ORTHOTICS/PROSTHETICS

This form should be used to document supervision under a Tennessee licensed orthotist/prosthetist or if licensed in another state certification from the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification.

TO BE COMPLETED BY APPLICANT:

(Name of Applicant) (Social Security Number)

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. T.C.A. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

TO BE COMPLETED BY APPLICANT'S EMPLOYER:

I hereby certify that the above named has successfully completed a clinical residency in prosthetics/orthotics according to Rule 1155-04.06.

(Employer Name) (Telephone Number)

(Address) (License Number)

(Certificate Number)

Dates of the applicant's work experience: (From: Month/Day/Year) (To: Month/Day/Year)

(Signature)

(Title)

(Date)



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PROGRAM VERIFICATION OF COMPLETION OF A QUALIFIED WORK EXPERIENCE OR INTERNSHIP IN PEDORTHICS

This form must be completed and signed by the supervising prosthetist, or podiatrist. This form must be mailed separately from the application and sent to the above address.

TO BE COMPLETED BY APPLICANT:

(Name of Applicant)

(Social Security Number)

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. T.C.A. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

TO BE COMPLETED BY APPLICANT'S EMPLOYER:

I hereby certify that the above named has successfully completed a qualified work experience program or internship in pedorthics and shall be no less than sixty (60) hours of work experience. The continuous and actual presence of the supervisor within the physical confines of the practice location is required.

(Employer Name)

(Telephone Number)

(Address)

(License Number)

(Certificate Number)

Dates of the applicant's work experience: _____
(From: Month/Day/Year)

(To: Month/Day/Year)

(Signature)

(Title)

(Date)